

Report on the  
**Community Development Diabetes Project**  
2008 to 2011



**Do not go where the path may lead, go instead where there is  
no path and leave a trail.**

Ralph Waldo Emerson

## **Acknowledgements**

The post of specialist diabetes worker in the community development (CD) team at NHS Bradford and Airedale was shared for two years between Carol Peltier and Mehzar Iqbal and for the third year of the project was held fulltime by the latter. During the life of the project it was supported by the whole CD team.

Many clinical professionals were involved in ways which were key to its success, working in community settings and going the extra mile beyond what they were commissioned to do, in an already demanding role and in a time of fast paced organisational change.

Many workers and volunteers in the voluntary and community sector, council, schools, faith groups and the private sector also played a pivotal role in helping the project engage with thousands of local people in informal settings in their own neighbourhoods.

**Report by Mehzar Iqbal community engagement worker,  
NHS Airedale, Bradford and Leeds community engagement team.**

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# Community development diabetes project 2008 - 2011

## Executive summary

### Impact of the project

The community development diabetes project was initiated to work in the community to raise awareness of risk factors and symptoms of type 2 diabetes, and to work in a number of selected GP practices to improve patient self management and reduce 'did not attend' (DNA) levels.

The project set four impact measures to evaluate its success:

**1 The number of people identified/referred with significant risk factors or symptoms.**

- ◆ 6,807 people were successfully engaged with in community settings as a result of the activity undertaken to 'proactively identify people who have undiagnosed diabetes or who are at increased risk of becoming diabetic' (JSNA). (Excluding 118 patients at practices.)
- ◆ Of these, 593 people (8.7%) who had two or more risk factors for diabetes were referred to their GPs.

**2 Increase in diabetes registers.**

- ◆ Of the 593 referrals, it has been confirmed that 103 have been to their GP. 77 were placed on diet and lifestyle change programmes and 26 were put on medication

**3 Reduced DNAs in practices.**

- ◆ All the patients selected by the practices for high DNAs attended intensive sessions with the CD worker. 'We have found that the patients are taking more control of their diabetes and their attendance rates have improved'. Dr Mughal.

**4 Improved self-management.**

- ◆ 6,913 people over the duration of the project were successfully given information on risk and symptoms, together with advice on healthy life choices that were tailored to their personal circumstances.
- ◆ 103 people were placed on diet and lifestyle change programmes or were put on medication by their GPs.
- ◆ For the 93 patients from the three practices for which figures are available, the average HbA1c reduction was 0.53%. The reduction was highest where we had worked longest, e.g. 0.93% at Dr. Mughal's practice.

The project has made a significant impact on each of these areas and clearly shows that investment in preventative measures is an effective way to address these issues.

## Recommendations

The key barriers to effective self management of diabetes and the identification of people with undiagnosed diabetes that are outlined later this report will continue to exist in hard to reach communities unless the lessons learnt from this project are acted upon.

Awareness raising and education are the two key elements that have been used to good effect to help tackle these issues via face-to-face, tailored interventions. However, funding for this project has now ended. It is therefore important to ensure that this project leaves a legacy of good practice and learning that will continue to benefit those communities most at risk and who are most at need.

To be truly effective it is strongly recommended that such an approach be embedded within the diabetes pathway as part of an early intervention strategy. It is also important to recognise that any early intervention programmes need to be accessible and delivered at a level that people can understand, taking into account that many people in the south Asian community have low levels of literacy.

It is important that discussion takes place as soon as possible to look at the options available to ensure that this essential early intervention and awareness raising work can continue and build upon the impressive results achieved over the past three years.



## Background and drivers

This report summarises the NHS Bradford and Airedale community health development team's three year diabetes project which concluded in July 2011.

### Key aims in the project proposal were:

- ◆ to be a source of knowledge and skills in how to empower “hard to reach” communities to enable better self management
- ◆ Identification of people with undiagnosed diabetes via the MOT and promotional work of the whole community development team and our partners.
- ◆ to assure the engagement of frequent non attendees to primary care diabetes clinics.
- ◆ To identify barriers to existing services and support that are not being accessed as illustrated by low QOF levels in some practices.
- ◆ to develop partnerships with local VCS organisations to expand this work.
- ◆ to support the development of new community led support groups, networks and services as appropriate.
- ◆ to put power into the hands of patients so that they are equal partners in managing their diabetes,

### The project was delivered in line with quality standards for preventing and identifying diabetes in the Diabetes National Service Framework:

**Standard 1:** The NHS will develop, implement and monitor strategies to reduce the risk of developing type 2 diabetes in the population as a whole and to reduce the inequalities in the risk of developing type 2 diabetes.

**Standard 2:** The NHS will develop, implement and monitor strategies to identify people who do not know they have diabetes.

### The project addressed the targets and priorities of the Bradford Joint Strategic Needs Assessment (JNSA):

- improved lifestyle services to prevent diabetes.
- early detection of diabetes and health screening to detect diabetes.
- improved management of people with diabetes.
- work with vulnerable and high risk groups to reduce inequalities.
- reducing complications from diabetes.
- improved self care support.

**The project also addressed 'future needs and gaps in provision' identified in the JSNA.**

- ◆ **lifestyle services to help prevent and reduce obesity in the population, which can increase the risk of becoming diabetic in the future.**
- ◆ **services to help detect diabetes and glucose impairment or intolerance earlier to proactively identify people who have undiagnosed diabetes or who are at increased risk of becoming diabetic due to glucose impairment or intolerance.**
- ◆ **improving glycaemic control and reducing blood pressure and cholesterol in people with diabetes, especially in deprived or disadvantages communities, vulnerable groups, e.g. people with learning difficulties, and ethnic minority groups, particularly south Asian populations.**
- ◆ **work with ethnic groups who have a higher incidence of diabetes and complications from diabetes, in particular south Asian populations.**
- ◆ **reducing the number of people presenting with complications from diabetes, being admitted to hospital or dying from diabetes or from illnesses caused by diabetes e.g. cardiovascular disease.**
- ◆ **services to support patients to become a more active participant in their care, enabling them to be more in control of their condition and to live with their condition with better health outcomes and an improved quality of life.**

#### **Why does diabetes matter?**

- It is a common disorder, with an estimated overall prevalence for diagnosed disease of 4%.
- The true prevalence is approximately 5.5%.
- The prevalence of disease increases steeply with age, and is higher in certain ethnic groups.
- The public health burden of diabetes is large.
- It is associated with a substantial burden of premature mortality, morbidity, suffering and financial cost, both through its macrovascular and microvascular complications.

**Joint Strategic Needs Assessment, 2009**

## Delivery of the project

The project was delivered in three phases. In the first year partnership networks and delivery methods were established in the Bradford 5 postcode area, to raise awareness of risk factors and symptoms, give advice on self management and prevention, identify people with, or at risk of, undiagnosed diabetes and refer them to their GPs .

Bradford 5 was chosen as a pilot area because it was identified as a diverse community with substantial numbers of people in high-risk groups. It also scored high on the indices of deprivation and had a high prevalence of diabetes.

In year two the project was rolled out into other, similar parts of Bradford district, where the C D team was focusing its work, having identified neighbourhoods in each constituency experiencing high levels of deprivation and health inequalities.

*'I felt very comfortable to have my assessment done at the centre because I have been a centre user for over 10 years now; it gives you that homely atmosphere'*  
**community centre user**

In year three these activities were continued. Additionally five practices were selected in liaison with the relevant commissioner and clinical lead, based on prevalence and the number of diabetics with poor control, as defined by a combination of HbA1c <7.5% and HbA1c level >9%<sup>1</sup>. At these practices a number of patients were identified, with poor

management and high rates of 'did not attend' (DNA) and sustained one to one work was carried out with them to improve both.

## Early identification and awareness raising work in the community

To ensure the most effective delivery of its work, the project consulted with local communities and relevant health professionals at meetings and workshops, and designed its events to take account of local views and conditions. What works in one community, though, does not necessarily work in another, so a number of different approaches and delivery methods were used to raise awareness of diabetes, which were tweaked and changed in response to expressed preferences and feedback, or to meet the needs of specific communities.

Our aim at the events we organised was to identify members of the community who had diabetes but had not yet been diagnosed by informing

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<sup>1</sup> HbA1c is a test, which indicates your blood glucose levels for the previous two to three months. The HbA1c measures the amount of glucose that is being carried by the red blood cells in the body.

people about the signs and symptoms of diabetes and doing diabetes risk assessments.

Risk assessments were carried out in line with National Institute for Health and Clinical Excellence (NICE), National Service Framework for diabetes (NSF) and Bradford Promoting Action on Clinical Excellence (PACE) guidelines. People that were identified as being at high risk or as having symptoms of diabetes were referred or signposted to the services that could best help them.



Partnership working with other professionals was essential to delivering a sustainable and coherent approach,

and the building of multi-agency relationships was vital for the success of the project.

## Working with the practices

During the third year of the project work was initiated in five GP practices selected on prevalence and the number of diabetics with poor control, as outlined above.

The selected practices were:

- the Mughal Medical Centre,
- Little Horton Medical Centre / Dr Gilkar,
- Avicenna Medical Centre,
- Primrose Surgery and
- Dr Mahmood's practice.

It was recognised that getting patients to take ownership of the management of their condition was the key to improving attendance. A dedicated C D worker, Mehzar Iqbal, worked intensively with the practices on their premises with patients who were at serious risk of developing complications because of poor self-management of their condition, reflected in their non-attendance at monitoring clinics.



The CD worker took on a caseload of diabetes patients that the practices reported as having had extreme difficulty engaging with. The practices felt they had exhausted all avenues to promote the importance of regular monitoring and to encourage these patients to attend the diabetes clinic. A caseload of 118 patients was

taken on across the five practices.

The CD worker had the time to explore patients' barriers to effective self management, signpost and facilitate access to appropriate local services, provide a structured approach to handling their condition and give them the information, means and confidence to manage their own diabetes effectively.

The aim was to build their trust in the CD worker and other NHS services and then to design a programme that would meet their needs and be easy to follow. We listened to the concerns of the patients and what support they said they needed. At the first meeting with the referred patients, the CD worker made it clear that he would be their advocate and that his job was to make sure they received the best possible care.

The patients' concerns, barriers and support needs were explored and a tailor made programme for managing their condition was then agreed to suit their needs. The CD Worker could signpost and facilitate access to locally available services and resources, e.g. exercise sessions at a local community centre. Patients were also empowered in relation to their condition with information and motivation and encouraged to take ownership themselves for the effective management of their diabetes.

### **Self management: barriers**

In helping, supporting and advising the patients, we found that they valued and acted on the advice given, as long as it was tailored to meet their needs. They also took on board the reality check about the likely outcome of non-attendance, understanding that they might be at a serious health risk from complications to their heart, eyes, kidneys etc.

The following factors emerged from the discussions with patients as barriers to good self-management of their diabetes.

- ◆ Because diabetes is so common, especially in some BME communities, people believe that it can't be that serious. It can be hard to convince people of the serious consequences if it is not properly controlled.
- ◆ Lack of understanding of the illness itself, even amongst diagnosed patients and their family members.
- ◆ Cultural attitudes that make it difficult to discuss illness in the home.
- ◆ Difficulties in coping with life in general, let alone managing their diabetes.
- ◆ Lack of awareness of appropriate local services and facilities and a lack of initiative in seeking these out.



- ◆ Lack of information on making Asian diets healthier. Much of the available healthy eating promotional material does not give any suggestions for healthy adaptations of Asian dishes.
- ◆ Mistaken beliefs about medication, in particular, the idea that a short course of treatment cures diabetes, when in fact it just brings it under control. As a result of this belief, there is a tendency not to continue taking the prescribed medication. There is also a belief in the efficacy of traditional south Asian remedies and the use of these in place of the GP's prescription.

### **Non attendance**

Specific reasons for non attendance at diabetes clinics were given as:

- the patient forgot appointment time;
- reminder calls or messages from the practice were not passed on to the patient by family members;
- the patient could not see the point in attending the appointments as they were not seeing any real benefits. They complained that they received the same information every time they attended. They had not necessarily taken these repeated messages on board though;
- the timing conflicted with work commitments; and
- patients did not understand how to inform the practice when they were unable to attend appointments.

### **Outcomes of the work with practices**

GP practices are busy and complex operations and this project was both innovative and being delivered at a time of fast-paced and extensive change in the NHS. Because of this, challenges were encountered in negotiating working arrangements with practices and in obtaining data to evaluate the work that was carried out. However, the project was fully supported by Dr Chris Harris, clinical lead for diabetes and chair of the diabetes pathways group, which had commissioned the project work. His direction and intervention helped us surmount difficulties.

All of the patients that Mehzar invited to work with him attended - at the Mughal practice on two separate occasions - although they were a group selected for high DNA rates. The face-to-face and group work, patience, and personal involvement put in by the CD worker fostered an environment of trust and belief in patients that they had the capacity to manage their own condition appropriately and effectively. One objective of the work with the GP practices was to lower the HbA1c of the patients referred to the CD worker and in many cases this did happen - of the 93 records accessed at the time of writing 73 have reduced (78.5%). It is notable that at Dr. Mughal's practice, where we have worked longest, the percentage of individual HbA1c reductions is highest among the practices at 82%, the average HbA1c reduction is highest

too, at 0.93, compared to the average of 0.53 across the 4 practices for which we have figures.

### **Feedback from the practices**

***We have noticed a marked improvement in attendance of Diabetes appointments and we now have 45% of patients with a HBA1C of >7 which is excellent and much better than previously.***

***The service you offered has definitely improved diabetes care here a lot, patients are attending appointments, we have had the DNA rate fall by over 27%, down to just 11% of patients failing to attend, and the majority of those are out of the country and told us they were going.***

Avicenna Medical Practice

***I wish to inform you that since Mehzar starting coming to our Practice and has been seeing Diabetic patients, we have found that the patients are taking more control of their diabetes and their attendance rates have improved, HbA1c have dropped and although not significantly even the slightest is an accomplishment.***

***I feel that if this service is carried forward and patients continue to get this level of service and education then we can tackle patients that are not in control of their illness and make a difference.***

Dr Zahir Mughal, Mughal Medical Centre

***When we spoke after your initial consultations with the patients and you informed of their concerns and their knowledge of the ailment, I was somewhat shocked about the information and outlook they have about the illness.***

Julie Shah, practice administrator, Mughal Medical Centre

These results clearly show that the preventative work undertaken by the CD Team made a real difference to the health prospects of these patients.

*I found the event extremely informative and empowering. I thought I knew everything about diabetes as a close family member suffers from it. I was shocked and surprised that what I actually thought was fact was actually myth. I thought only obese people can get diabetes and that it was only because of diet. I now know a number of factors effect diabetes: exercise, age, ethnicity and if a close family member suffers from it. I will make sure my family member takes his medication on time and watches what he eats and takes regular exercise so he can manage and control his diabetes.'*

**community centre user**

## Impact of the project

The Community Development Diabetes Project set four impact measures to evaluate its success the following paragraphs summarises its impact under each of these measures.

### 1 The number of people identified/referred with significant risk factors or symptoms.

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The project has made a significant impact on each of these areas and has clearly shown that investing in preventative measures is cost-effective. 1 to 1 work on raising awareness and patient self-confidence in managing their diabetes is shown to be a worthwhile measure, both from an NHS standpoint, and in terms of the health and quality of life of patients.

## Recommendations

The key barriers to effective self management of diabetes and the identification of people with undiagnosed diabetes that are outlined in this report will continue to exist in hard to reach communities unless the lessons learnt from this project are acted upon.

Awareness raising and education are the two key elements that have been used to good effect to help tackle these issues via face-to-face, tailored interventions. However, funding for this project has now ended. It is therefore important to ensure that this project leaves a legacy of good practice and learning that will continue to benefit those communities most at risk and who are most at need.

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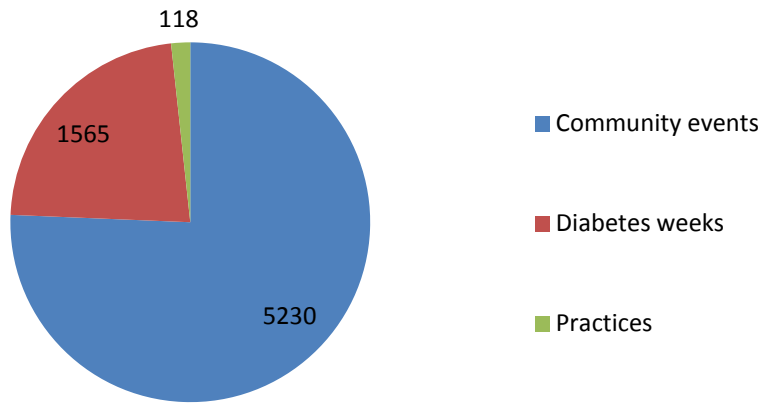
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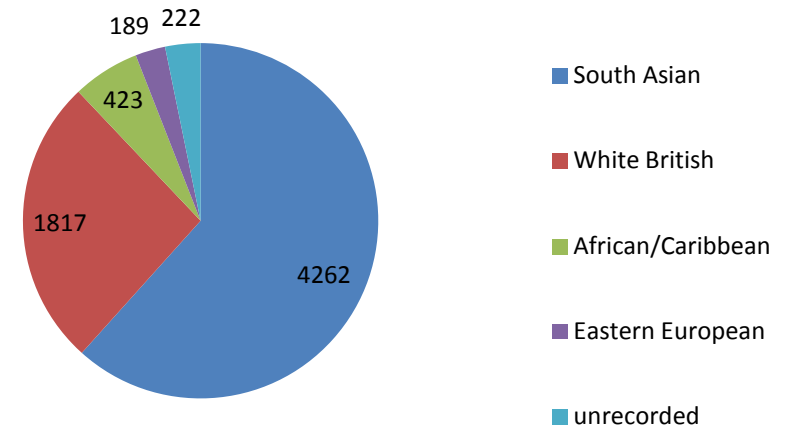
# Community Development Diabetes Project 2008 -2011

## Work in community settings raising awareness of risk factors, symptoms, prevention and early identification

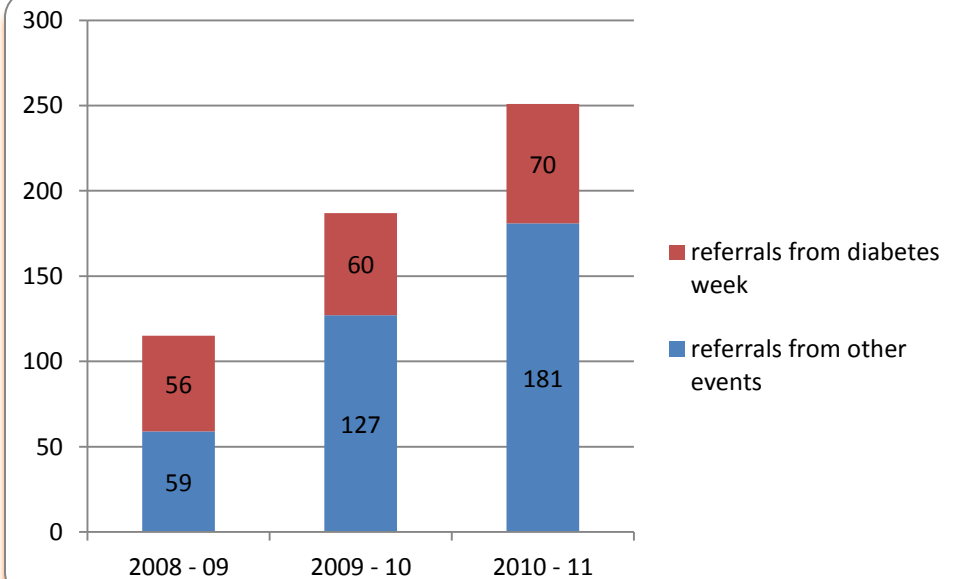
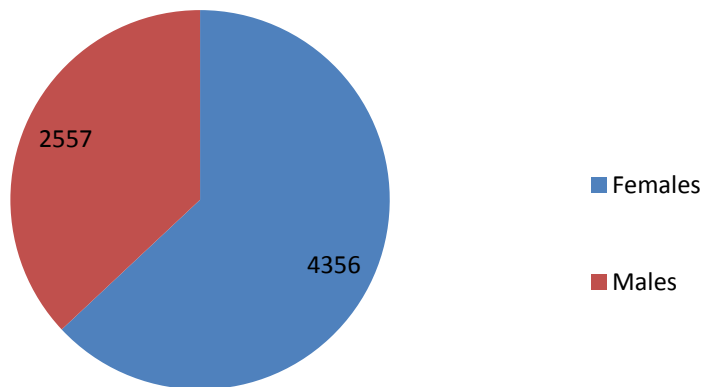
People engaged by project activity - total 6,913



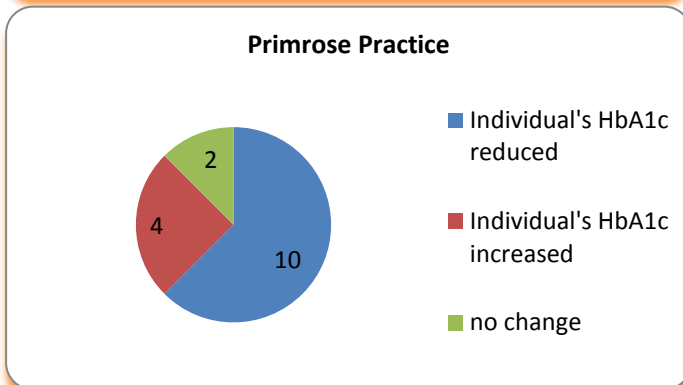
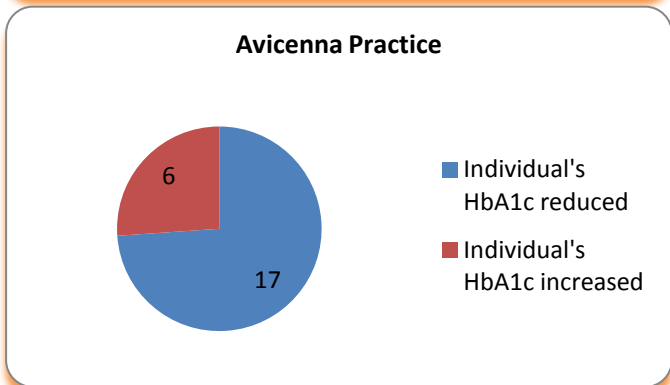
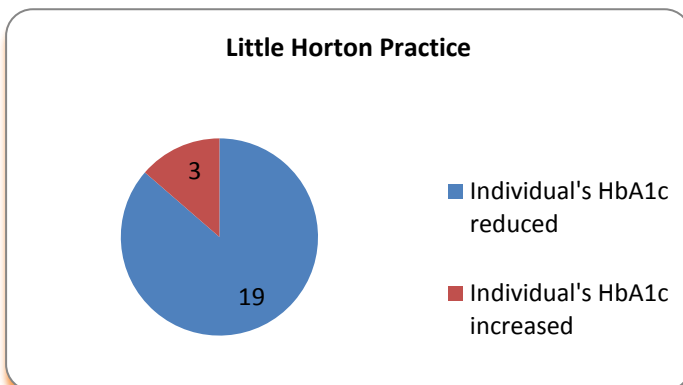
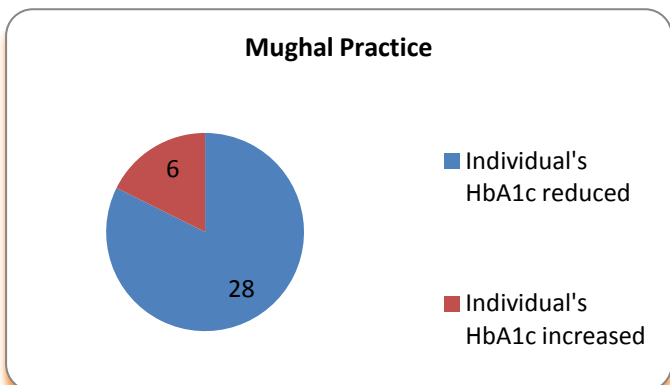
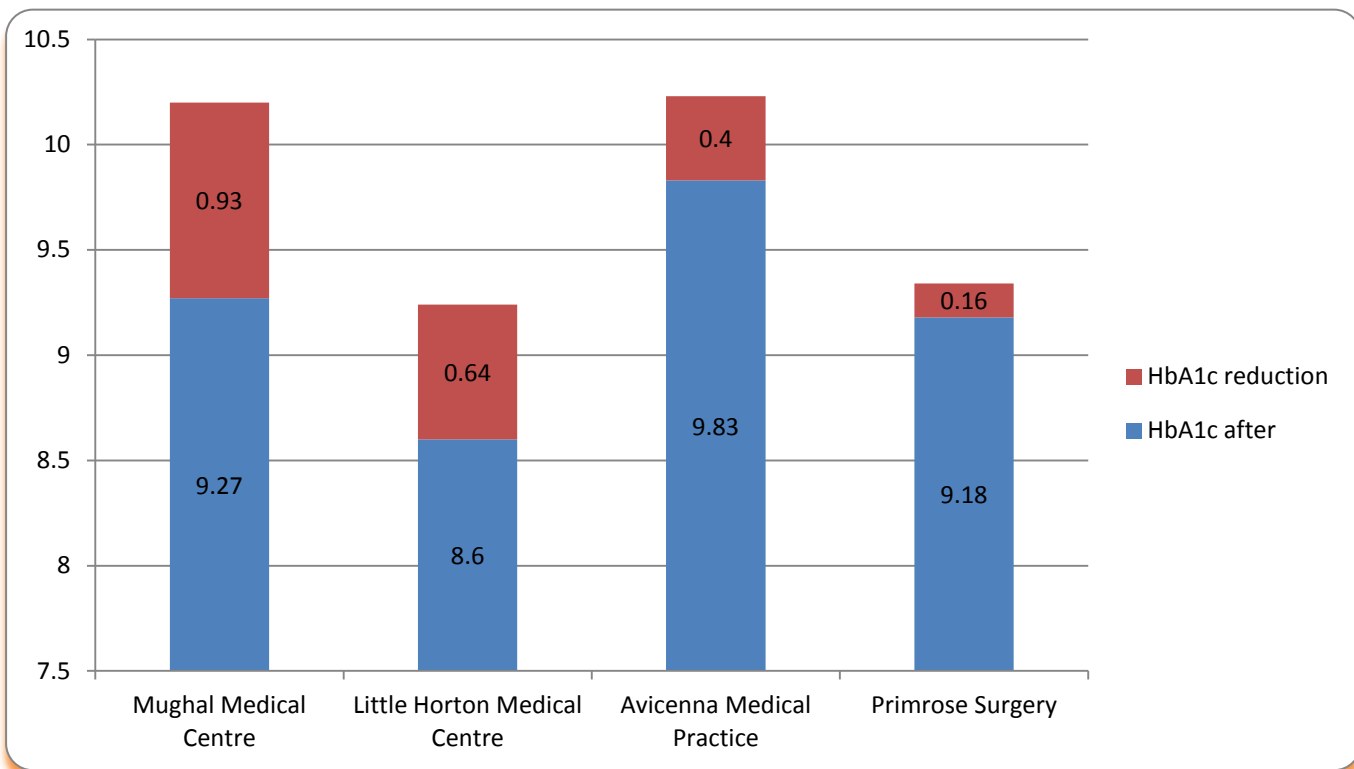
Ethnicity of attendees - total attendance 6,913



Gender of attendees - total attendance 6,913



## Community Development Diabetes Project 2008 -2011 Work in practices to support self management and reduce HbA1c



**This report has been compiled by the NHS Airedale, Bradford and Leeds Community  
Engagement Team October 2011.**

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